Confidential Health Information

for Jan Hulka, MS, Certified Holistic Health Practitioner

NAME	BIRTH DATE / /	DATE / /

Address_____ City_____ State_____ Zip_____
Email_____ Phone#_____ home_____cell
Emergency Contact Name and Phone#_____

CHIEF COMPLAINTS	MONTH/YEAR	DAILY ACTIVITIES AFFECTED
1.	/	
2.	/	
3.	/	

PAIN:
On a pain scale of 0=none to 10=unbearable, what is your pain level: On a Good Day____ On a Bad Day____ Today_____

Please describe your pain: ☐ Throbbing ☐ Sharp ☐ Aching ☐ Tingling ☐ Burning ☐ Numb ☐ Shooting

What other treatments have you had for this condition: ☐ PT/OT ☐ Acupuncture ☐ Chiropractic ☐ Massage
Other:_____

Do you exercise regularly? ☐ NO ☐ YES What type of exercise (frequency/week):_____
_____

Are you taking any: ☐ medication ☐ homeopathic and/or herbal remedies ☐ vitamins
What for:_____

DIET and personal habits:
What type of diet o you follow? ☐ Gluten-free ☐ Dairy-free ☐ Sugar-free ☐ Vegetarian/Vegan
☐ No specific diet Other:_____

How many times do you usually eat per day?_____ Meals _____ Snacks

On average, how much water do you drink per day?_____8 oz. glasses. What other non-alcoholic beverages do you drink? ☐ Decaffeinated coffee ☐ Regular coffee ☐ Tea ☐ Regular soda ☐ Diet soda

Do you drink alcoholic beverages? ☐ NO ☐ YES How many drinks per week?_____

Do you currently smoke or chew tobacco? ☐ NO ☐ YES How many per day?_____

SLEEP:
On average, how many hours do you sleep? _____ hours
Dou you fall asleep easily? ☐ Yes ☐ No
Do you feel rested during the day? ☐ Yes ☐ No
Haw many times do you wake at night? _____

PRECAUTIONS:
Please help me be aware of any of the following Precautions:

Are you pregnant? ☐ Yes ☐ No _____month Are you nursing? ☐ Yes ☐ No

Latex Allergies ☐ Yes ☐ No Other Allergies/Allergic reactions:_____

Do you have a heart condition ☐ Yes ☐ No Are you wearing a pacemaker? ☐ Yes ☐ No

Are you wearing ☐ Metal implants ☐ Stents ☐ Breast implants ☐ Catheters ☐ Shunts ☐ Dentures

Other implantation of medical or dental devices: _____

Range of motion restrictions/activity limitations: _____

Swallowing/food precautions _____

Breathing/suctioning _____

Positioning Issues _____

Is there any Concern regarding a change in Intercranial Pressure? ☐ Yes ☐ No

Other:_____

Hospitalization, injuries, surgeries, disorders & approx. dates**:**_____

_____

_____

_____

What is your dental history (*braces, root canals, dentures, bridges, other & approx. dates*):_____

_____

Please identify any significant illnesses/conditions/circumstances regarding family medical history:_____

_____

_____

YOUR OVERALL HEALTH: Please rate your overall health ☐ Excellent ☐ Very good ☐ Good ☐ Fair Poor

What would you like to do that you are currently having difficulty with/unable to do?_____

_____

What are your health goals/intentions?

1._____

2._____

3._____

How can I help you to achieve these goals/intentions?

1._____

2._____

3._____

REVIEW OF SYSTEMS: (Please check any item which describes recent or ongoing symptoms)

General ☐ None Apply

☐ Unexplained weight loss/gain ☐ Unexplained Fatigue/weakness/loss of energy ☐ Night sweats
☐ Fever, chills ☐ Difficulties performing regular daily activities ☐ Loss of feeling of well-being
Other:_____

Skin ☐ None Apply

☐ New or change in mole ☐ Rash ☐ Itching ☐ Eczema ☐ Slow healing ☐ Unusual dryness
Other:_____

Breast ☐ None Apply

☐ Breast lump ☐ Brest pain ☐ Nipple discharge
Other:_____

Ears/Nose/Throat ☐ None Apply

☐ Ear pain ☐ Hearing loss ☐ Ringing in ears ☐ Nosebleeds ☐ Chronic nasal congestion ☐ Bleeding gums
☐ Toothache ☐ Breath odor ☐ Trouble swallowing ☐ Frequent sore throat, hoarseness
Other:_____

Eyes ☐ None Apply

☐ Change in vision ☐ Eye pain/irritation ☐ Eye redness
Other:_____

Cardiovascular ☐ None Apply

☐ Chest pain/discomfort/pressure ☐ High blood pressure ☐ Palpitations (fast or irregular heartbeat)
☐ Abnormal heart rhythm or murmur ☐ Circulation problems (cold feet or hands) ☐ Swelling of ankles
☐ High cholesterol Other:_____

Respiratory ☐ None Apply

☐ Cough ☐ Wheeze ☐ Shortness of breath ☐ Asthma ☐ Loud snoring/altered breathing during sleep
Other:_____

Gastrointestinal ☐ None Apply

☐ Heartburn/reflux/indigestion ☐ Stomach/abdominal pain ☐ Loss of appetite ☐ Nausea/vomiting
☐ Bloating ☐ Blood in stool ☐ Diarrhea ☐ Constipation ☐ Hemorrhoids
Other:_____

Liver ☐ None Apply

☐ Hepatitis A ☐ Hepatitis B ☐ Hepatitis C ☐ Hepatitis D ☐ Cirrhosis
Other:_____

Genitourinary ☐ None Apply

☐ Leaking urine (incontinence) ☐ Burning with urination ☐ Blood in urine
☐ Nighttime urination or increased frequency ☐ Discharge: penis or vagina ☐ Concern with sexual function
Other:_____

Musculoskeletal ☐ None Apply

☐ Neck pain ☐ Back pain ☐ Muscle/joint pain ☐ Muscle weakness ☐ Muscle spasm or twitching

Other:_____

Endocrine ☐ None Apply

☐ Heat or cold sensitivity (any thyroid problems) ☐ Excessive thirst or hunger (diabetes)

Other:_____

Hematologic/Lymphatic ☐ None Apply

☐ Swollen glands/lymph nodes ☐ Easy bruising ☐ Easy/unusual/hard to stop bleeding ☐ Blood clots

Other:_____

Neurological ☐ None Apply

☐ Concussion ☐ Headache ☐ Memory loss ☐ Fainting ☐ Dizziness ☐ Numbness/tingling ☐ Seizure

☐ Unsteady gait ☐ Frequent falls ☐ History of significant head injury ☐ Altered consciousness or black-outs

Other:_____

Allergic/Immune ☐ None Apply

☐ Hay fever ☐ Allergies ☐ Frequent or unusual infections

Other:_____

Emotional/Psychological ☐ None Apply

☐ Anxiety/nervousness/stress/irritability ☐ Guilt ☐ Sleep problem ☐ Difficulty concentrating ☐ Depression

☐ Loss of memory ☐ History of physical or mental abuse ☐ Mood swings ☐ Worry about things ☐ PSD

Other:_____

Women only ☐ None Apply

☐ Pre-menstrual symptoms (bloating cramps, irritability) ☐ Problem with menstrual periods

☐ Hot flashes/night sweats ☐ Pain with intercourse

Other:_____